

**CABINET FOR HEALTH AND FAMILY SERVICES**  
**Department for Medicaid Services**  
**Division of Policy and Operations**  
**(As Amended at ARRS, September 8, 2020)**

**907 KAR 1:604. Recipient cost-sharing.**

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.20, 447.21, 447.50, 447.52, 447.54, 447.55, 447.56, 447.57, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa - 1397jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.90, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments for Medicaid recipients. This administrative regulation establishes the provisions relating to Medicaid Program copayments.

Section 1. Definitions. (1) ~~["Community spouse" means the individual who is married to an institutionalized spouse and who:~~

~~(a) Remains at home in the community; and~~

~~(b) Is not:~~

~~1. Living in a medical institution;~~

~~2. Living in a nursing facility; or~~

~~3. Participating in a 1915(c) home and community based services waiver program.~~

(2) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

(2) [(3)] "Department" means the Department for Medicaid Services or its designee.

~~(3) [(4)] "Dependent child" means a child, including a child gained through adoption, who:~~

~~(a) Lives with the community spouse; and~~

~~(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.~~

~~(5) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.~~

~~(6) "Drug" means a covered drug provided in accordance with 907 KAR 23:010 for which the Department for Medicaid Services provides reimbursement.~~

(7) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

~~(4) [(8)] "Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).~~

~~(9) "KCHIP" means the Kentucky Children's Health Insurance Program.~~

~~(10)~~ "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

~~(5)~~~~(11)~~ "Medicaid Works individual" means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B) would be considered to be receiving supplemental security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

~~(6)~~~~(12)~~ "Nonemergency" means a condition that does not require an emergency service pursuant to 42 C.F.R. 447.54.

~~(13)~~ "Office visit for behavioral health care" means a visit to a clinician or prescriber in which a:

~~(a) Diagnosis of a behavioral health condition is made;~~

~~(b) Treatment decision related to the diagnosis of a behavioral health condition is continued; or~~

~~(c) Prescription for a behavioral health condition is:~~

~~1. Initially issued; or~~

~~2. Renewed.~~

~~(14)~~ "Recipient" is defined ~~by~~~~[in]~~ KRS 205.8451(9).[

~~(15)~~ "Visit" means:

~~(a)1. An encounter; or~~

~~2. A series of encounters that are performed on the same date of service at the same physical location;~~

~~(b) Between a recipient or enrollee and a health care provider during which time a covered service is delivered; and~~

~~(c) A service that occurs:~~

~~1. In person; or~~

~~2. Via telehealth if authorized by 907 KAR 3:170.]~~

Section 2. Copayments. (1) Except as provided by subsection (4) of this section, the following table shall establish the copayment amounts that a recipient shall pay, unless the recipient is otherwise exempt from cost sharing.

<u>Benefit</u>	<u>Copaym ent Amount</u>
<u>Emergency room for a nonemergency visit</u>	<u>\$1</u>
<u>Prescription and over-the- counter drugs</u>	<u>\$1</u>
<u>Ambulance services provided to individuals in need of nonemergency health transportation services</u>	<u>\$1</u>

(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement, unless the recipient has already met any copayment obligation for the year pursuant to Section 3(1)(b) of this administrative regulation.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(4) A prescription co-payment shall not apply to:

(a) Certain antipsychotic medications;

(b) Contraceptives for family planning;

(c) Tobacco cessation medications;

(d) All covered diabetes or diabetic supplies;

(e) Pregnant recipients;

(f) Long-term care residents; or

(g) Any recipient exempted pursuant to Sections 3 or 5 of this administrative regulation.

Section 3. Copayment General Provisions and Exemptions. (1)(a) Cost-sharing or copayments for the delivery of Medicaid services within the Commonwealth shall not exceed the amounts established in the table in Section 2 of this administrative regulation.

(b) After paying for one (1) copayment each calendar year for any service or product within the table established in Section 2 of this administrative regulation, a recipient shall not be subject to additional copayments or cost-sharing for that service or any other Medicaid covered service or product for the remainder of that calendar year.

(2) A Medicaid beneficiary who is younger than nineteen (19) years of age shall be exempt from the copayment or cost-sharing requirements established pursuant to this administrative regulation.

(3) A copayment shall not be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child or a pregnant woman.

(4) The department shall impose no cost sharing for an individual or recipient who is exempt pursuant to 42 C.F.R. 447.56.

(5) A provider shall not deny services to a recipient who cannot pay any required cost sharing.

(6) Any amount of uncollected copayment by a provider from a recipient shall not be considered a debt to the provider.

(7) A provider shall not collect:

(a) A copayment from an enrollee for a service or item if a copayment is not imposed for that service or item; or

(b) Any copayment or cost sharing from an enrollee that is greater than the copayment amounts established in the table in Section 2 of this administrative regulation.

(8) Cumulative cost sharing for copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.

(9) In response to a declared emergency relating to or rationally related to healthcare or public health, the department may waive or direct the waiving of all required cost-sharing for all Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries

not already exempted from this administrative regulation, including a geographic or age-related subpopulation.

Section 4. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in paragraph (b) of this subsection.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no more than 150 percent of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.

(2) An individual whose family income is equal to or below 100 percent of the FPL shall not be required to pay a monthly premium.

(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling.

Section 5. Provisions for Enrollees. A managed care organization:

(1) Shall not impose a copayment on an enrollee that exceeds a copayment established in this administrative regulation; and

(2) May impose on an enrollee:

(a) A lower copayment than established in this administrative regulation, if possible;  
or

(b) No copayment.

Section 6. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7. Appeal Rights. An appeal of a department decision regarding the Medicaid

eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. Federal Approval and Federal Financial Participation. The department's copayment provisions and any coverage of services established in this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation; and
- (2) Centers for Medicare and Medicaid Services' approval.

Section 9. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on May 13, 2014. [Copayments. (1) The following table shall establish the:

~~(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) and (2) of this administrative regulation; and~~

~~(b) Corresponding provider reimbursement deductions.~~

Benefit	Copay- ment Amount
Acute inpatient hospital admission	\$50
Outpatient hospital or ambulatory surgical center visit	\$4
Emergency room for a nonemergency visit	\$8
DMEPOS	\$4
Podiatry office visit	\$3
Chiropractic office visit	\$3
Dental office visit	\$3
Optometry office visit	\$3
General ophthalmological office visit	\$3
Physician office visit	\$3
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	\$3
Office visit for behavioral health care	\$3
Office visit to a rural health clinic	\$3
Office visit to a federally qualified health center or a federally qualified health center look-alike	\$3
Office visit to a primary care center	\$3
Physical therapy office visit	\$3

<del>Occupational therapy office visit</del>	<del>\$3</del>
<del>Speech-language pathology services office visit</del>	<del>\$3</del>
<del>Laboratory, diagnostic, or radiological service</del>	<del>\$3</del>
<del>A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age</del>	<del>\$0</del>
<del>Brand name drug</del>	<del>\$4</del>
<del>Generic drug</del>	<del>\$1</del>
<del>Brand name drug preferred over generic drug</del>	<del>\$1</del>
<del>Pharmacy product class: certain antipsychotic drugs</del>	<del>\$1</del>
<del>Pharmacy product class: contraceptives for family planning</del>	<del>\$0</del>
<del>Pharmacy product class: tobacco cessation</del>	<del>\$0</del>
<del>Pharmacy product class: diabetes supplies, blood glucose meters</del>	<del>\$0</del>
<del>Pharmacy product class: Diabetes supplies, all other covered diabetic supplies</del>	<del>\$4 for first fill, \$0 for second fill and beyond, per day</del>
<del>Pharmacy patient attribute: pregnant</del>	<del>\$0</del>
<del>Pharmacy patient attribute: long-term care resident</del>	<del>\$0</del>
<del>Pharmacy patient attribute: under eighteen (18) years of age</del>	<del>\$0</del>
<del>KI-HIPP participant</del>	<del>\$0]</del>
<del>[Kentucky HEALTH: Medically Frail</del>	<del>\$0</del>
<del>Kentucky HEALTH: Former Foster Care Youth up to 26 years of age</del>	<del>\$0</del>
<del>Kentucky HEALTH: enrollee current on premiums</del>	<del>\$0]</del>

**~~[(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement.~~**

~~(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.~~

~~Section 3.][Copayment General Provisions and Exemptions. (1) The department or any MCO shall not utilize or require cost-sharing or copayments in the delivery of Medicaid services within the Commonwealth.~~

~~(2)(a) A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age shall be exempt from the copayment or cost-sharing requirements established pursuant to this administrative regulation.~~

~~(b) A beneficiary receiving services via a 1915(c) home and community based waiver shall not be subject to cost-sharing established pursuant to this administrative regulation.~~

~~(c) A beneficiary receiving services in a long term care facility shall not be subject to cost-sharing established pursuant to this administrative regulation.~~

~~(d) In response to a declared emergency relating to or rationally related to healthcare or public health, the department may waive or direct the waiving of all required cost-sharing for all Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries not already exempted from this administrative regulation, including a geographic or age-related subpopulation.~~

~~(e) In response to a contracted actuarial analysis demonstrating cost-effectiveness or cost-neutrality, the department may waive or direct the waiving of all cost-sharing for all Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries not already exempted from this administrative regulation, including a geographic or age-related subpopulation. As necessary, the department shall seek federal financial participation and approval to implement this paragraph.~~

~~(2)(a) A copayment shall not be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child or a pregnant woman.~~

~~(b) The department shall impose no cost sharing for an individual or recipient who is exempt pursuant to 42 C.F.R. 447.56.~~

~~(c) A provider shall not deny services to a recipient who:~~

~~1. Makes less than or equal to 100 percent of the federal poverty level even if the recipient cannot pay any required cost-sharing; or~~

~~2. Makes more than 100 percent of the federal poverty level if:~~

~~a. The recipient cannot pay any required cost sharing; and~~

~~b. The provider does not have a policy that applies to all patients that allows for denial of services upon nonpayment of a cost sharing obligation.~~

~~(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined by [in] [42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor, or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.~~

~~(4) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).~~

~~(5)(a) Any amount of uncollected copayment by a provider from a recipient with income above 100 percent of the Federal Poverty Level at the time of service provision shall be considered a debt to the provider if that is the current business practice for all patients.~~

~~(b) Any amount of uncollected copayment by a provider from a recipient with income at or below 100 percent of the Federal Poverty Level at the time of service provision shall not be considered a debt to the provider.~~

~~(6)] A provider shall[:~~

~~(a) Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation or have a written process for attempting to collect the copayment;~~

~~(b) Not waive a copayment obligation as imposed by the department for a recipient;][and][~~

~~(c) Document each attempt to collect the copayment or collect a copayment at the time a benefit is provided or at a later date not to exceed six (6) months from the date of provision of the service; and~~

~~(d)][not collect a copayment from an enrollee for a service or item if a copayment is not imposed for that service or item.]~~

~~(7) Cumulative cost sharing for copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.~~

~~(8) In accordance with 42 C.F.R. 447.15 and 447.20, the department shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient.]]~~

~~Section 3[4]. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:~~

~~1. Based on income used to determine eligibility for the program; and~~

~~2. Established in paragraph (b) of this subsection.~~

~~(b) The monthly premium shall be:~~

~~1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no more than 150 percent of the FPL;~~

~~2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and~~

~~3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.~~

~~(2) An individual whose family income is equal to or below 100 percent of the FPL shall not be required to pay a monthly premium.~~

~~(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.~~

~~(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.~~

~~(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.~~

~~(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.~~

~~(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.~~

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~~(b) No copayment.]/~~

~~Section 4][6]/. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.~~

~~(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:~~

- ~~(a) 42 C.F.R. 438.52; or~~
- ~~(b) 42 C.F.R. 438.114(c).~~

~~Section 5][7]/. Appeal Rights. An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~Section 6][8]/. [Applicability of KAR Title 895. If eligible for Kentucky HEALTH, an individual subject to this administrative regulation shall also comply with any applicable requirements established pursuant to KAR Title 895.~~

~~Section 9.] [Federal Approval and Federal Financial Participation. The department's copayment provisions and any coverage of services established in this administrative regulation shall be contingent upon:~~

- ~~(1) Receipt of federal financial participation; and~~
- ~~(2) Centers for Medicare and Medicaid Services' approval.~~

~~Section 7][9][10]/. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on May 13, 2014.]~~

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